TEACHERS' RETIREMENT BOARD

HEALTH BENEFITS COMMITTEE

SUBJECT: Medicare Supplement Program Request for Proposal - Track A-1

ITEM NUMBER: 5

ATTACHMENT(S):

ACTION: X

DATE OF MEETING: June 8, 2000

INFORMATION:

PRESENTER: Annette Wimmer

The first draft of the Request for Proposal (RFP) to insurance companies and health plans for a potential Medicare Supplement program for CalSTRS retirees enrolled in Medicare Part A & B is attached for Committee review and discussion. The RFP was designed to elicit information from bidders to enable the Committee to determine if such a program will meet CalSTRS needs based on the seven Guiding Principles the Committee adopted in May. Attachment II identifies the potential bidders list.

Principle One: A CalSTRS Medicare supplement program will build on and enhance the trust that members have in CalSTRS.

There are three key factors that should be carefully assessed to determine if the health benefit plan meets this standard:

1. Inclusion of CalSTRS members in determining the needs. The continued involvement of Health Benefit Task Force, the Ad Hoc retiree committee and the various constituent groups helps assure that the Committee continues to gather member opinions.

2. Sustainability of the program. If CalSTRS discontinued a health program that some members have come to rely upon, it would shake the confidence of all members.
   - Applicable RFP Sections: 1) Contract Term (4-year); 2) Financial Provisions (multi-year premium setting strategy); 3) Required Disease Management program.

3. Comparability with other available programs. The plan design options, the retiree's premium share, and the customer care reputation of the selected bidders are all important in assuring members that the CalSTRS health plan is an attractive option.
   - Applicable RFP Sections: 1) Proposed plan benefits and options; 2) Geographic coverage requirements; 3) Possible inclusion of expanded Behavior Health coverage and Alternative Medicine services; 4) customer services standards; and 5) multi-year premium strategy.
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Principle Two. A CalSTRS Medicare supplement program will offer a choice of providers and plans/carriers.

The draft RFP contemplates at least two Medicare Supplement plan designs, two Medicare+Choice plans and two or more insurance carriers or health plans.

- Applicable RFP Sections: 1) Medicare Supplement Benefit Design; 2) Medicare+Choice Benefit Design; 3) Potential Bidders List.

Principle Three: CalSTRS Medicare supplement program will clearly define the CalSTRS financial exposure before it is launched. (Initially, only fully insured offerings will be considered.)

The RFP contemplates only selecting bidders who agree to accept full (all risk) contracts for the financial exposure for at least four years. Further, the RFP expects successful bidders to enter into a multi-year contract with a multi-year premium agreement.

- Applicable RFP Sections: a) Medicare Supplement Benefit Design; 2) Medicare+Choice Benefit Design; 3) Potential Bidders List

Principle Four: A CalSTRS Medicare supplement program will only be implemented after the completion of a five-year strategic plan establishing benchmark performance needs and milestones in several key areas: 1) Enrollment; 2) Funding Strategy; 3) Long-term cost expectations; 4) Cost containment efforts from the outset; and 5) Commitment to planned innovation enhancements.

The data garnered from the RFP responses will be crucial to the development of a practical, workable strategic plan. The RFP could be viewed as the market survey step of the strategic plan.

Principle Five: A CalSTRS Medicare supplement program will serve all areas of California and attempt to offer a viable out-of-state option.

The RFP sets the Medicare supplement benefits within the framework of the standard MediGap designs, so that national insurance carriers will be encouraged to bid. This should enhance the probability of viable out of state plan coverage. The California domiciled bidders will be measured and evaluated on the breadth of each bidders geographic service area(s). The RFP expects geographically specific premiums. This should increase the potential responders and enhance the California service areas, which could be served.

- RFP Sections Applicable: 1) Medicare Supplement Benefit Design; 2) Contract Requirements & Standards 3) Potential Bidders List

Principle Six: A CalSTRS Medicare supplement program will strive to offer a competitive benefit package with affordable premiums.

The RFP responses will be evaluated on the demonstrated effectiveness of then bidder's programs in the areas of patient (case) management, disease management and alternative medicine capabilities. As possible benefit enhancements, the RFP asks that hearing and eye examinations be included in the plan designs. Generally, these benefits are not available in the individual Medicare supplement marketplace.

- Applicable RFP Sections: 1) Medicare Supplement Benefit Design; 2) Medicare+Choice Benefit Design; 3) Contract Requirements & Standards

Principle Seven: A CalSTRS Medicare supplement program will encourage districts that provide retiree health benefits to include the CalSTRS plan among the options.

This principle is not addressed in the RFP. The Medicare supplement strategic plan would include a thorough examination including competitive this principle.

MEDICARE SUPPLEMENT BENEFIT DESIGN

The following table details the services to be provided for the CalSTRS Medicare Supplement Plan. All members eligible for this program will have Medicare Part A and Part B.

CalSTRS expect to select a carrier(s) that is:

- Administratively efficient
- Technologically competitive
- Effective in implementing innovative managed care strategies
- Effective coordination and integration of disease management, preventive care, member education, and demand management
- Prepared to provide excellent customer service
- Committed to making our members a priority
- Willing to share data with CalSTRS and other CalSTRS contractors
- Utilizing state-of-the-art technology, such as electronic data interchange; advanced customer service and claims technology

Benefits	CalSTRS Medicare-Plan Medigap Model C	CalSTRS Medicare-Plan Medigap Model F	CalSTRS Medicare-Plan Medigap Model J
Doctors & Hospital Choice	Any physician Hospital Network OK	Any physician Hospital Network OK	Any physician Hospital Network OK
OUT PATIENT MEDICAL SERVICES			
Part B-Deductible	Plan pays 100%	Plan pays 100%	Plan pays 100%
Charges above Medicare allowable (applies to all OP benefit categories)	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Doctor Office Visits	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Outpatient Mental Health	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 80% of Medicare allowable. Member pays 20% above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Outpatient Substance Abuse Care	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Outpatient Surgery	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.

Benefits	CalSTRS Medicare-Plan Medigap Model C	CalSTRS Medicare-Plan Medigap Model F	CalSTRS Medicare-Plan Medigap Model J
Emergency Room Care	100% of balance, member pay $0 Worldwide coverage	100% of balance, member pay $0 Worldwide coverage	100% of balance, member pay $0 Worldwide coverage.
Urgently Needed Care (This is not emergency care, and in most cases, is out of the service area.)	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Ambulance Services (medically necessary)	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Durable Medical Equipment	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Prosthetic Devices (includes pacemakers, braces, artificial limbs and eyes, etc.)	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Diagnostic Tests, X-Rays and Lab Services	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.

Benefits	CalSTRS Medicare-Plan Medigap Model C	CalSTRS Medicare-Plan Medigap Model F	CalSTRS Medicare-Plan Medigap Model J
Radiation Therapy	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Manual Manipulation of the Spine	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Podiatry Services	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Outpatient Rehabilitation Occupational Therapy Physical Therapy Speech & Language Therapy	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
INPATIENT CARE			
Part A Deductible	Plan pays 100% Member pays 0$	Plan pays 100% Member pays 0$	Plan pays 100% Member pays 0$
Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	Member pays $0 each service	Member pays $0 each service	Member pays $0 each service
Inpatient Mental Health Care	Member pays $0 each service	Member pays $0 each service	Member pays $0 each service

Benefits	CalSTRS Medicare-Plan Medigap Model C	CalSTRS Medicare-Plan Medigap Model F	CalSTRS Medicare-Plan Medigap Model J
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	Member pays $0 (following a 3 day hospital stay) 100 days each benefit period	Member pays $0 (following a 3 day hospital stay) 100 days each benefit period	Member pays $0 (following a 3 day hospital stay) 100 days each benefit period
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services etc.)	Plan pays $0 Member pays 100% of non-Medicare paid charges.	Plan pays 100% of Medicare allowable. Member pays amount above allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Hospice	Plan pays 100% of charges above Medicare allowable.	Plan pays 100% of charges above Medicare allowable.	Plan pays 100% of charges above Medicare allowable.
PREVENTIVE SERVICES			
Annual Screening Mammograms (for women)	Plan pays 80% of Medicare allowable. Member pays balance.	Plan pays 100% of Medicare allowable. Member pays amount over allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule
Pap Smears and Pelvic Exams (for women)	Plan pays 80% of Medicare allowable. Member pays balance.	Plan pays 100% of Medicare allowable. Member pays amount over allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Annual Bone Mass Measurement (for men and women)	Plan pays 80% of Medicare allowable. Member pays balance.	Plan pays 100% of Medicare allowable. Member pays amount over allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.

Benefits	CalSTRS Medicare-Plan Medigap Model C	CalSTRS Medicare-Plan Medigap Model F	CalSTRS Medicare-Plan Medigap Model J
Biannual Colorectal Screening Exams (for men and women)	Plan pays 80% of Medicare allowable. Member pays balance.	Plan pays 100% of Medicare allowable. Member pays amount over allowable.	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Annual Prostate Cancer Screening Exams (for men)	Plan pays 80% of Medicare allowable. Member pays balance.	Plan pays 100% of Medicare allowable. Member pays amount over allowable.	Plan pays100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Diabetes Monitoring (includes coverage for glucose monitors, test strips, lancets and self-management training)	80% allowable fee schedule. Member pays 20% of balance.	100% allowable fee schedule. Member pays amount above fee schedule	Plan pays 100% up to UCR-based fee schedule. Member pays any amount above UCR-based fee schedule.
Immunizations • **Pneumococcal pneumonia vaccine** • **Flu vaccine** • **Hepatitis B vaccine**	Plan pays all amounts above Medicare allowable.	Plan pays all amounts above Medicare allowable.	Plan pays all amounts above Medicare allowable.
Routine Physical Exams	Plan pays 80% of allowable UCR based fee schedule. Member pays balance.	Plan pays 100% of allowable UCR based fee schedule. Member pays amount above fee schedule	Plan pays 100% of allowable UCR based fee schedule. Member pays amount above fee schedule
Annual Vision Services Exam	Plan pays up to $75 a year.	Plan pays up to $75 a year.	Plan pays up to $75 a year.
Biannual Hearing Testing	Plan pays up to $100 every other year.	Plan pays up to $100 every other year.	Plan pays up to $100 every other year.

OTHER ISSUES			
Prescription Drug Coverage This coverage will be as a separate contract/policy. It will not be included in the Medicare Supplement of Medicare + Choice plans.		Please see questionnaire….	
Bidder is encouraged to propose Network use Incentives?		Please detail proposal, see questionnaire section #…	

MEDICARE + CHOICE BENEFIT DESIGN

The following table details the services to be provided for the CalSTRS Medicare + Choice Plan. All members eligible for this program will have Medicare Part A and Part B.

CalSTRS expect to select carrier(s) that is:

- Administratively efficient
- Technologically competitive
- Effective in implementing innovative managed care strategies
- Effective coordination and integration of disease management, preventive care, member education, and demand management
- Prepared to provide excellent customer service
- Dedicated to making our members a priority
- Willing to share data with CalSTRS administrators
- Utilizing state-of-the-art technology, such as electronic data interchange; advanced customer service and claims technology

In addition, our members need to have access to credentialed health care providers that provide cost-effective, quality care leading to good health outcomes.

Benefits	CalSTRS Medicare +Choice Copays $0	CalSTRS Medicare +Choice Copays $5	CalSTRS Medicare +Choice Copays $10
Doctors & Hospital Choice	PC Network: In most cases: • You must go to network doctors, specialists and hospitals. • You need a referral to go to network specialists. You need a referral to go to non-network doctors, specialists or hospitals.	PC Network: In most cases: • You must go to network doctors, specialists and hospitals. • You need a referral to go to network specialists. You need a referral to go to non-network doctors, specialists or hospitals.	PC Network: In most cases: • You must go to network doctors, specialists and hospitals. • You need a referral to go to network specialists. You need a referral to go to non-network doctors, specialists or hospitals.
Doctor Office Visits	Co-pays: $0 for each primary care doctor office visit. $0 for each specialist office visit.	Co-pays: $5 for each primary care doctor office visit. $5 for each specialist office visit.	Co-pays: $10 for each primary care doctor office visit. $10 for each specialist office visit.
Outpatient Mental Health	Co-pays: $5 for each individual visit. $0 for each group visit.	Co-pays: $5 for each individual visit. $0 for each group visit.	Co-pays: $10 for each individual visit. $5 for each group visit.
Outpatient Substance Abuse Care	Co-pays: $0 for each individual visit. $0 for each group visit.	Co-pays: $5 for each individual visit. $0 for each group visit.	Co-pays: $10 for each individual visit. $5 for each group visit.
Outpatient Surgery	Co-pay: $5	Co-pay: $10	Co-pay: $25
Emergency Room Care	Co-pay: $0 waived if admitted.	Co-pay: $5 waived if admitted.	Co-pay: $10 waived if admitted.
Urgently Needed Care (This is not emergency care, and in most cases, is out of the service area.)	$5 for each visit at an urgent care facility; same exception as above.	$10 for each visit at an urgent care facility; same exception as above.	$15 for each visit at an urgent care facility; same exception as above.
Ambulance Services (medically necessary)	No charge.	No charge.	No charge.

Benefits	CalSTRS Medicare +Choice Copays $0	CalSTRS Medicare +Choice Copays $5	CalSTRS Medicare +Choice Copays $10
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
Durable Medical Equipment	No charge.	No charge.	No charge.
Prosthetic Devices (includes pacemakers, braces, artificial limbs and eyes, etc.)	Co-pays: $0 for each pacemaker. 10% for each other prosthetic device.	Co-pays: $50 for each pacemaker. 20% for each other prosthetic device.	Co-pays: $100 for each pacemaker. 20% for each other prosthetic device.
Diagnostic Tests, X-Rays and Lab Services	Co-pays: $0 for each diagnostic test. $0 for each x-ray. Office copayment if not and emergency.	Co-pays: $5 for each diagnostic test. $5 for each x-ray. Office copayment if not and emergency.	Co-pays: $10 for each diagnostic test. $10 for each x-ray. Office copayment if not and emergency.
Radiation Therapy	Co-pays: $0 for each visit.	Co-pays: $5 for each visit.	Co-pays: $10 for each visit.
Manual Manipulation of the Spine	Co-pays: $0 per visit – limited to 30 visits a year.	Co-pays: $5 per visit – limited to 30 visits a year.	Co-pays: $10 per visit – limited to 30 visits a year.
Medically Necessary Foot Care (includes care for medical conditions affecting the lower limbs)	Co-pays: $0 for each visit.	Co-pays: $5 for each visit.	Co-pays: $10 for each visit.
Outpatient Rehabilitation Occupational Therapy Physical Therapy Speech & Language Therapy	Co-pays: $5 for each visit up to $30; then you pay $0 for each visit.	Co-pays: $10 for each visit up to $50; then you pay $5 for each visit.	Co-pays: $15 for each visit up to $75; then you pay $10 for each visit.

Benefits	CalSTRS Medicare +Choice Copays $0	CalSTRS Medicare +Choice Copays $5	CalSTRS Medicare +Choice Copays $10
INPATIENT CARE			
Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	Co-pays; $0 for each hospital stay.	Co-pays; $50 for each hospital stay up to $150 each year.	Co-pays; $100 for each hospital stay up to $300 each year.
Inpatient Mental Health Care	Co-pays; $0 for each hospital stay. 190-day lifetime limit does not apply.	Co-pays; $50 for each hospital stay up to $150 each year. 190-day lifetime limit does not apply.	Co-pays; $100 for each hospital stay up to $300 each year. 190-day lifetime limit does not apply.
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	Co-pays; $0 for days 1-100. $5 for days 100 and on. 3-day prior hospital stay is not required.	Co-pays; $5 for days 1-100. $10 for days 100 and on. 3-day prior hospital stay is not required.	Co-pays; $10 for days 1-100. $15 for days 100 and on. 3-day prior hospital stay is not required.
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services etc.)	Co-pays; $0 for all covered home health visits.	Co-pays; $5 for all covered home health visits.	Co-pays; $10 for all covered home health visits.
Hospice	Co-pays; $0 for each visit.	Co-pays; $5 for each visit.	Co-pays; $10 for each visit.
PREVENTIVE SERVICES			
Annual Screening Mammograms (for women with Medicare age 40 or older)	Co-pays; $0 No referral necessary for network providers	Co-pays; $5 No referral necessary for network providers	Co-pays; $10 No referral necessary for network providers

Benefits	CalSTRS Medicare +Choice Copays $0	CalSTRS Medicare +Choice Copays $5	CalSTRS Medicare +Choice Copays $10
Pap Smears and Pelvic Exams (for women with Medicare)	Co-pays; $0 for the pap smear every 2 years; annually if high risk. $0 for the pelvic exam for 1 exam each year. No referral necessary for network providers.	Co-pays; $5 for the pap smear every 2 years; annually if high risk. $5 for the pelvic exam for 1 exam each year. No referral necessary for network providers.	Co-pays; $10 for the pap smear every 2 years; annually if high risk. $10 for the pelvic exam for 1 exam each year. No referral necessary for network providers.
Bone Mass Measurement (for people with Medicare who are at risk) Oesteperousis.	Co-pays; $0 for 1 exam each year. No referral necessary for network providers.	Co-pays; $5 for 1 exam each year. No referral necessary for network providers.	Co-pays; $10 for 1 exam each year. No referral necessary for network providers.
Colorectal Screening Exams (for people with Medicare who are age 50 and older)	Co-pays; $0 for 1 exam each year. No referral necessary for network providers.	Co-pays; $5 for 1 exam each year. No referral necessary for network providers.	Co-pays; $10 for 1 exam each year. No referral necessary for network providers.
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	Co-pays; $0 for 1 exam every 2 years. No referral necessary for network providers.	Co-pays; $5 for 1 exam every 2 years. No referral necessary for network providers.	Co-pays; $10 for 1 exam every 2 years. No referral necessary for network providers.
Diabetes Monitoring (includes coverage for glucose monitors, test strips, lancets and self-management training)	Co-pays; $0 for 1 exam every 2 years. No referral necessary for network providers.	Co-pays; $5 for 1 exam every 2 years. No referral necessary for network providers.	Co-pays; $10 for 1 exam every 2 years. No referral necessary for network providers.
Immunizations • **Pneumococcal pneumonia vaccine** • **Flu vaccine** **Hepatitis B vaccine**	Co-pays; $0 No referral necessary. $0 No referral necessary. $0 No referral necessary for network providers.	Co-pays; $0 No referral necessary. $0 No referral necessary. $0 No referral necessary for network providers.	Co-pays; $0 No referral necessary. $0 No referral necessary. $0 No referral necessary for network providers.

Benefits	CalSTRS Medicare +Choice Copays $0	CalSTRS Medicare +Choice Copays $5	CalSTRS Medicare +Choice Copays $10
ADDITIONAL BENEFITS			
Outpatient Prescription Drugs	Not covered.	Not covered.	Not covered.
Routine Physical Exams	Co-pays; $0 for each exam each year.	Co-pays; $5 for each exam each year.	Co-pays; $10 for each exam each year.
Vision Services	Co-pays; $0 for each eye exam, limited to 1 exam each year.	Co-pays; $5 for each eye exam, limited to 1 exam each year.	Co-pays; $10 for each eye exam, limited to 1 exam each year.
Dental Services	Co-pays; $0 for each routine cleaning, x-ray and exam each year up to 2 visits each year.	Co-pays; $5 for each routine cleaning, x-ray and exam each year up to 2 visits each year.	Co-pays; $10 for each routine cleaning, x-ray and exam each year up to 2 visits each year.
Hearing Services	Co-pays: $0 for each hearing screening test up to 1 visit each year.	Co-pays: $5 for each hearing screening test up to 1 visit each year.	Co-pays: $10 for each hearing screening test up to 1 visit each year.
Podiatry Services	Co-pays; $0 for each visit up to 2 visits each year.	Co-pays; $5 for each visit up to 2 visits each year.	Co-pays; $10 for each visit up to 2 visits each year.
Annual Deductible	Not Applicable	Not Applicable	Not Applicable
Annual out-of-pocket maximum	None	None	None

Performance Standards

CalSTRS requires all carriers and administrators to agree to performance measures and minimum target standards. This chart provides examples of the performance measures and target standards.

PERFORMANCE MEASURES	MINIMUM TARGET
Accuracy and timeliness of ID Cards and EOC's	• 100% in 5 working days.
Customer Service Response Response to complaints and inquires Telephone inquires Telephone speed to answer Telephone abandonment rate	 10 working days of receipt 90% resolved on first contact 5% busy signal ➢ 98% of calls answered within 30 seconds 5% abandon rate annually
Claim processing Turnaround time Financial accuracy (percentage of dollars paid correctly) Procedural accuracy	 99% non-investigational claims in 30 work days. 95% of investigational claims in 30 work days. 99% 97%
Pre-certification	95% completed in 2 work days
Inpatient concurrent review	95% completed in 1 work day
Timeliness and accuracy of financial reports.	Timeliness is defined for a monthly report as being received within 30 calendar days after the end of the month to be reported. 45 days for a quarterly report and 60 days for an annual report. 99% of reports are error free.

The bidder is encouraged to present a list of additional performance measures that are believed to be relevant and demonstrate service quality. During final negotiations CalSTRS expects the selected Contractor(s) to enter into a mutually agreed to set of measures.

Contract Requirements and Standards

Requirement	Evaluation Standards/Priorities	
Questionnaire Completion: All sections completed for each contract type bid.	• Responsive • Concise • Consistent w/ Contract Type • Consistent w/ Other Responses • Appropriate and Requested Documentation • Verifiable on Request	
Contract Term: Four (4) Years	• Acceptance of a four year contract	
Financial Provisions:	• Multi-Year Premiums • Multi-Year Maximum Premium Increases • Illustrative 1/1/2001 Premiums • Geographic Region Premium Relationships • Multiple Plan-types Bid w/ Verifiable Administrative Savings	
Administration: Customer Service, Claims Capability, Automation	• Service Standards: Procedures, Monitoring, Training • Client Recommendations; Service Reputation • Automation Experience • Information Technology Plans with Verifiable Current Capabilities	
Plan Design	• Medicare Supplements o Proximity of benefit design to models o Chronic patient support & management system o Commitment to cooperate with outside disease management contractor & prescription drug contractor • Medicare+Choice o Geographic Area(s) o Chronic Patient Support & Management System o Commitment to cooperate with outside CalSTRS prescription drug benefit contractor(s) o Alternative Medicine experience & network • HMO Supplement o Geographic Area(s) o Chronic patient support & management system o Commitment to cooperate with outside CalSTRS prescription drug benefit contractor(s) o Alternative Medicine experience & network	

	• Medicare Select o Proximity of benefit design to models o Chronic patient support & management system o Commitment to cooperate with outside disease management contractor & prescription drug contractor o Patient Incentives for network utilization	
Provider Network	• Geographic Distribution • Extent of Specific Specialists Need by Medicare Population • Medical Group-Plan Collaboration o Medical Management o Physician Education & Training o Solvency Safeguards o Medical Group involvement in disease management • Medical Group(s) Stability • Tertiary Hospital Network	
Patient & Case Management	• Experience in geriatric patient management • Demonstrated competence in patient education • Demonstrated capability to maintain patient records • Demonstrated capability to identify candidates for disease management programs.	
Marketing	• Experience in Medicare Marketing • Demonstrated success w/Seniors • Verifiable commitment to collaborating w/CalSTRS to assure viable enrollment.	

MEDICARE SUPPLEMENT PLANS
POTENTIAL BID LIST

BLUE SHIELD	
COMBINED INSURANCE CO. OF AMERICAN	
STANDARD LIFE & CASUALITY	
BANKERS LIFE & CASUALITY INS. CO	
BLUE CROSS OF CALIFORNIA	
CALFARM INSURANCE CO	
CELTIC LIFE INSURANCE CO	
CENTRAL STATES HEALTH & LIFE CO OF OMAHA	
CONTINENTAL GENERAL INSURANCE CO	
GE LIFE & ANNUITY ASSURANCE CO	
HEALTH NET MEDICARE SELECT	
MONUMENTAL LIFE INSURANCE CO OF AMERICA	
MUTUAL OF OMAHA INSURANCE CO	
MUTUAL PROTECTIVE INSURANCE CO	
PEOPLES BENEFIT LIFE INSURNACD CO	
PHYSICIANS MUTUAL INSURANCE	
PIONEER LIFE INSURANCE CO	
UNION LABOR LIFE INSURANCE CO	
UNITED AMERICAN INSURANCE CO	
UNITED HEALTHCARE/AARP	

HMO
POTENTIAL BID LIST

UNIVERSAL CARE	
CIGNA	
AETNA/US HEALTHCARE	
PRUCARE	
HEALTH PLAN OF REDWOODS MAXICARE	
BLUE SHIELD HMO	
CALIFORNIA CARE	
SECURE HORIZON (PACIFICARE)	
HEALTHNET	
KAISER FOUNDATION HEALTH PLAN	
LIFEGUARD	
WESTERN HEALTH ADVANTAGE	

CALIFORNIA STATE TEACHERS' RETIREMENT SYSTEM
REQUEST FOR PROPOSAL
(INSERT TITLE)
RFP NUMBER _____

PROPOSAL QUESTIONNAIRE

FIRM NAME: _____

MAIN ADDRESS: _____

_____

CONTACT: Name: _____

Title: _____

Telephone/Facsimile: _____

E-Mail: _____

A.

B.

C. Please list at least three (3) clients as references for whom your firm has provided similar services. For each reference, provide company name, address, and name and telephone number of contact person.

D. If your firm has provided services to the State of California within the past three years, list the agency, the contract number, their address, contact person, and telephone number.

G. Provide a resume for each potential contract participant who will exercise a major administrative, policy, or consultant role, as identified by the Proposer.

H. Has there been any litigation against your firm in the past three (3) years? If yes, explain.

_____ _____
Authorized Signature Date

_____ _____
Printed Name Printed Title

NAME OF COMPANY

1. Please indicate your organization's legal name and primary address. Please provide the same information on the parent company.

2. Is this response for:
   - Insured Medigap Style Fee for Service Plan_____
   - HMO Medicare Supplement_____
   - Medicare+Choice_____
   - Medicare Select _____

A. Organizational and Financial Information

1. Organizational and Tax Status

a. Ownership and Tax Status

Name of Owner(s) / Sponsors	% Owned	Address of Owner(s)

b. Tax Status: _____Profit _____Non Profit

c. Has ownership change in past 2 years? _____Yes _____No
If yes, describe the change below:

d. Is future change in ownership/sponsorship being considered?
_____ Yes _____No If yes, describe the change below:

e. Provide the information requested below on Key Contacts:

Title	Contact Name	Date Hired for Position	Phone	FAX	e-mail
CONTACTS REGARDING RESPONSES TO THIS REQUEST FOR PROPOSAL					
Primary Contact					
Secondary Contact					
KEY MANAGEMENT CONTACTS					
Chief Executive Officer					
Vice President Marketing					

Account Representative					
Medical Director					
Medicare Director					
Claims Manager					
Provider Relations Manager					
Customer Services Manager					

f. (1) Are there any restrictions or pending reviews by State or Federal authorities for noncompliance with State or Federal regulations? ____Yes _____No. If yes, please explain in Attachment XX.

(2) What was the date of the last Department of Corporations quality audit? List recommendations, and status of compliance as Attachment XX.

g. Have there been any legal actions brought against the company during the past year or are any pending that may have a significant impact on the plan's financial status?____Yes _____No If yes, please explain as Attachment XX and include the amount of financial penalties, if any.

h. Total Enrollment

		July 1, 2000		
Type of Service	**Subscribers (Employees)**	**Total Lives (Members)**		
PPO				
Medicare Supplement, HMO				
Medicare Supplement, FFS				
Medicare+Choice				

2. Financial Information – Parent Company

a. Financial Performance Indicators

	1998	1999
Total Revenue*		
Net Income		
Net Worth		
Debt-to-Service Ratio		

*Actual revenue billed and booked by the close of the reporting period for all group and direct pay payers (should not include prospective payments). The reporting period has passed, so this number should be available on plan financial statements (booked as revenues earned). If you are unable to provide this data, please state the reason.

b. Overall Loss Ratio

	1998	1999
Overall Loss Ratio		
Copayment Revenue		

c. Please provide the following for each period requested.

	1997	1998	1999
PMPM Medical Cost			
PMPM Administrative Cost			

3. Financial Information – For Bidding Entity

a. Financial Performance Indicators

	1998	1999
Total Revenue*		
Net Income		
Net Worth		
Debt-to-Service Ratio		

*Actual revenue billed and booked by the close of the reporting period for all group and direct pay payers (should not include prospective payments). The reporting period has passed, so this number should be available on plan financial statements (booked as revenues earned). If you are unable to provide this data, please state the reason.

b. Overall Loss Ratio

	1998	1999
Overall Loss Ratio		
Copayment Revenue		

c. Please provide the following for each period requested.

	1997	1998	1999
PMPM Medical Cost			
PMPM Administrative Cost			

4. Nomenclatures Differences

List below any questions in this section "B" in which you were either unable to answer or if a different definition of a difference between your company's definition and the one provided in this RFP.

Question No.	Alternate Definition Used

B. Provider Network - HMO Network only

Person responsible for completing this Section of questionnaire response:

Contact
Name_____Title_____
Address_____Telephone_____
Fax_____E-mail_____

1. General Provider Network Information *(HMO Applicants Only)*

a. Please describe your service area by county as Attachment XX. Please list each county in one of CalSTRS' six regions: 1) LA Basin; 2) Other Southern CA; 3) San Francisco Bay Area; 4) Urban-Central Valley; 5) Other Northern CA; 6) Rural CA.

b. Based upon the CalSTRS member zip code information included in the census data for this RFP, provide a GeoAccess report for your service area indicating the number of eligible members, within five, ten and thirty miles of a primary care physician. Primary care physician is defined to mean family practice physicians, and internal medicine physicians.

c. Does your plan offer reciprocal coverage with plans in other areas for retired members who maintain two primary residences, such as "snow birds?" Reciprocal is defined to mean a contractual agreement with another health plan or with health plans within your own corporation to provide primary care (non-emergent) in both locations.

2. Physicians Network Access *(HMO Applicants Only)*

a. Please complete the following tables detailing the health plan's service area by type of physician. Provide the number of contracted providers currently participating in the health plan product(s) being bid by your organizations. Provide total percentage board certified primary care physicians and specialist physicians by CalSTRS regions. Specifically listing individual physicians with board certification in gerontology, in the primary care section.

(1) "Primary Care Physician" (PCP) is defined to mean family practitioners, internal medicine physicians, and gerontologists.

County	Zip Code(s)	Number of Primary Care Physicians	Percent Board Certified	Percent Board Eligible	# Accepting New Patients as of 9/30/99
1a. TOTAL					

(2) Obstetricians/Gynecologists

County	Zip Code(s)	Number of Obstetricians/ Gynecologists	Percent Board Certified	Percent Board Eligible	# Accepting New Patients as of 9/30/99
1b. TOTAL					

(3) Specialists

County	Zip Code(s)	Number of Specialists	Percent Board Certified	Percent Board Eligible
1c TOTAL				

(4) Alternative Care Providers: chiropractors, podiatrists, dieticians, naturopaths, acupuncturists and psychologists.

County	Zip Code (s)	Number of Alternative Care Providers	# Accepting New Patients as of September 30, 1999
1d. TOTAL			

3. **Are alternative care benefits available? Can they be offered on an individual member's selection basis?** *(All Bidders)*

4. **The number of contracted providers currently participating in the health plan product(s) being bid by your organization.** Provide total percentage of specialist physicians certified in the specialty the physician is listed in the provider directory. Do not combine board certified and board eligible percentages. Do not count providers more than once due to multiple specialties, office locations, or provider category (i.e., obstetrics/gynecology). Utilize the format below. *(All Bidders)*

Provider Category	Number	# Board certified	# Board Eligible
Obstetrics/Gynecology			
Allergy			
Cardiology			
Dermatology			
Emergency Medicine			
Endocrinology			
Family Practice			
Gastroenterology			
Gerontology			
General Surgery			
Hematology/Oncology			
Internal Medicine			
Nephrology			
Neurology			
Neurological Surgery			
Ophthalmology			
Orthopedics			
Otolaryngology (ENT)			
Pediatrics			
Psychiatry			
Plastic Surgery			
Pulmonology			
Rheumatology			
Radiology			
Thoracic/Cardiovascular Surgery			
Urology			
Other MDs (specify):			
Total # Specialists			
% Board Cert. Specialists			
Alternative care Providers Podiatry			
Chiropractic			
Other/Alternative Medicine			
Subtotal - # Alternative Providers			
GRAND TOTAL – ALL PROVIDERS			

5. Based upon the census data provided, identify California counties where your network may not have adequate capacity to meet the potential demand. *(All Bidders)*

a. Indicate the percentage (%) of health plan contracted physicians in the service area identified as your service area in Section 1, who have voluntarily (physician-initiated) and involuntarily (plan-initiated) terminated participation. Utilize the format below . *(HMO Bidders only)*

PHYSICIAN TURNOVER								
	Provider Initiated (Voluntary) Turnover				Plan Initiated (Involuntary) Turnover			
	1/1/00 -	12/31/00	1/1/98	12/31/99	1/1/99	12/31/99	1/1//98	12/31/98
Type of Provider	#	%	#	%	#	%	#	%
Primary Care								
OB/GYN								
Other Specialist								
Total Physicians								

6. Inpatient Hospital Network/Access *(HMO and Medicare Select Bidders)*

a. List the health plan's institutions and associated/affiliated Medical Groups.

Medical Groups	**Institutions**	**Location (City/State)**

7. Transplant and Specialized Treatment Centers *(All Bidders***)**

a. List the health plan's facility/institutions/providers for transplant services. Utilize the format below.

Facility/Institutions/ Providers	**Location (City/State)**	**Organ Transplant**	**Is this a Medicare Approved Center?**

b. When choosing an institution for organ-specific transplants which of the following criteria are reviewed?

Criteria	Yes	No
Institutional volume	☐	☐
Length of time program in place	☐	☐
Physician/team training	☐	☐
Volume per year	☐	☐
Average length of stay	☐	☐
Significant complication rate	☐	☐
Patient survival rate	☐	☐
Graft survival rate	☐	☐
Other	☐	☐

c. List the health plan's facility/institutional/providers for highly specialized services. Please identify which facility/institution/ provider, if any, the health plan exclusively channels to for highly specialized services.

Facility/Institutions/ Providers	Location (City/State)	Specialty Service	Selection Criteria

8. Behavioral Health Rider *(All Bidders)*

a. Does your organization offer add-on or rider mental health and substance abuse benefit(s)? _____
Are these rider(s) supported by an additional or different network provider? _____(provide two tables if your rider has a different network.)

Provide the total number of behavioral health care specialists available to the membership, utilizing the format below. Behavioral health specialists are defined as psychiatrists, psychologists, social workers, marriage counselors, and family counselors. List each specialty separately.

County	Zip Code(s)	Number of Specialists	Percent Board Certified	Percent Board Eligible
5a. Total				

b. Provide the total number of inpatient behavioral health care facilities available to membership. Inpatient behavioral health care facilities are defined as those providing either mental health or chemical dependency treatment, which should be listed separately.

County	Zip Code(s)	Number of Inpatient Facilities
5b. Total		

c. Of the providers in 5a and 5b above, indicate the number of behavioral health specialists and facilities available for specialized needs or services utilizing the format below.

Specialty Area	Number of Providers	Diagnosis Specialty	Dual Diagnosis Specialist
Families			
Elderly			

9. Network Quality *(HMO Bidders required. Medicare Select optional.)*

a. Please provide you plan's provider credentially procedures :

1. Hospitals
2. Physicians
3. Alternative care practitioners
4. Behavior health practitioners

b. Please provide you plan's policies and procedures for monitoring medical group:

1. Solvency
2. Credentialling (if delegated)
3. Medical management
4. Provider education and training.

c. Does your plan provide general or targeted education to the physician or medical group?
Specifically addressing:

- Treatment guidelines
- Cost-effective decision making protocols
- Newly approved medical treatment and medication protocols
- New medical technology use
- Alternative therapies

Is this education product specific? Please include samples.

C. Quality of Care

1. Transition of Care *(HMO and Medicare Select Bidders)*

What are your standards in assuring transition of care for new members to the plan? How do you propose to identify new members who need assistance in transition of case management? Provide information for patients with:

a. Cancer
b. Congestive Heart Failure (CHF)
c. Diabetes
d. Osteoporosis
e. Heart Disease, Stroke
f. Others - be specific

2. Disease Management *(All Bidders)*

CalSTRS is interested in understanding the efforts undertaken by your organization to improve the health and health outcomes of members. Therefore, we request information on the health promotion and disease management programs currently operational in your health plan. Since disease management means different things to different parties, we are using the following (7) criteria required elements of a disease management program for the purposes of this document. Please apply these criteria when determining your response to the following three questions.

Disease Management Program Criteria

- Mechanism to identify members "at risk" and likely to benefit from early intervention and education
- Written clinical guidelines, reviewed at least annually by plan (preferably with a high degree of provider input/acceptance)
- Coordinated program to assess and meet member/family/provider learning needs and member self-care needs.
- Ongoing monitoring mechanism to evaluate program success and improvement opportunities over time
- Dedicated staff coordinating efforts with provider related medical management and member education.
- Regular program report includes health status after intervention and member reciprocity.
- Ability to provide group specific reporting.

a. For disease management programs that meet the above criteria and are currently operational in your health plan, please provide the date of implementation. Please provide documentation of clinical guidelines used and program results from the implementation date forward.

Disease or Condition	Date Began	Member Copay Amount	Provider Fee or Capitation Cost
Asthma*			
COPD			
Depression*			
Low Back Pain			
Diabetes* and Diabetes HGB A1C Monitoring			
GERD			
PUD/H. Pylori			
HIV/AID			
Breast Cancer*			
Prostate Cancer*			
Hypertension			
CAD/Hyperlipidemia			
ASA Therapy Post MI			
Congestive Heart Failure*			
Other Coronary Program			
Stroke Prevention			
Atrial Fib/Anticoagulant Use			
Beta Blocker Post MI			
Elderly Prevention / Falls*			
Hip Fracture Management*			
Osteoporosis*			
Other(s)			

b. For the specified disease management programs designated by the asterisks in the previous question above, please complete the following grid if the plan has a program in place.

Disease State or Conditions	Asthma	Depression	Diabetes	Etc.
Define how members are targeted. Please define the criteria used to identify the at risk population (age, gender, familial history, HRA questions, pharmaceutical use, etc.)				
# of Current Members Eligible for Program				
# of Current Members in the Program				
How does the health plan identify potential members to physicians? How often does this occur?				
How does the health plan factor physician participation in its disease management programs into physician performance measures and incentives?				

Please list the objectives or performance measures the health plan have used or will use to evaluate the success of this program?				
Please provide the date of the most recent program evaluation and the recommendations that evolved from this process? If feedback was collected from participating physicians and patients please attach a copy of the tool(s) used to gather this information.				

c. For any program identified above not provided internally by health plan staff, please complete the following.

Program Name	Contractor / Date of Contract	Oversight Monitoring Mechanism	Frequency Program is to be Reviewed	Date of Last Documented Review

Please provide contract provisions related to contractor performance requirements and limitation provisions

d. Disease Management Attachments – for the specified programs described above, please attach the following as Attachment D-2.

- A copy of the clinical practice guideline(s) supporting the program
- Sample reports showing statistics coverings physician compliance with the program.
- Sample reports provided to physicians listing patients who are enrolled in the program or should be enrolled.
- Samples of the targeted member outreach communication materials.
- Member education materials related to the disease and integrated into the program.
- Physician education materials related to the guidelines and the program.
- Tools used to evaluate effectiveness of program and opportunities for improvement.

e. 24 - Hour Nurse Support Call Line.

Do your services include a 24-hour nurse support call line that would be available to members under this contract? If yes, please complete the following table describing its function.

Type of Service	Date Implemented	Identify Vendor, if Delegated	Type of Staff (Lay person, Nurse, Pharmacist, MD)
Physician Referral			
Triage			
Disease Specific Information – Live Voice			
Disease Specific Information – Recordings			
Drug Information – Live Response			
Drug Information – Recordings			
General Health Information – Live			
Other			

3. Wellness and Health Prevention/Promotion *(All Bidders)*

a. Please identify and complete the following information describing any preventive health promotion and educational activity designed specifically to assist senior plan members in maintaining their health.

Program Name	Identify Vendor if other than health plan staff	Date Program Started	Population Targeted	Frequency of Program	Member Copay Amount	Provider Fee

4. Medical Technology Assessment. *(All Bidders)*

As Attachment D-3, provide the health plan's policy and procedure for assessing new medical technology including time frames for determination of coverage and notification of decisions to members and providers. Include committee structure, function and frequency of meetings. Specifically, address the role HCFA guidelines plan in these decisions.

D. Customer Service and Satisfaction *(All Bidders each section)*

1. Customer Service

a. Provide the following information on telephonic member services representatives for each Medicare product on which you are bidding utilizing the format below.

	Telephonic Member Services Representatives
Number of representatives exclusive to Medicare + Choice	
# of multi plan representatives	
Actual ratio of representatives to members	
Standard ratio of representatives to members	
Annual turnover rate	• 1997 CY_____% • 1998 CY_____% • 1999 CY_____%
Annual calls per member	
Plan standards for	• Length of calls • # of calls @ hour @ rep • Research time @ rep @ day
Total calls	

b. If member service representatives are allowed to make claims adjustments, what is the dollar threshold?

c. Hours of operation, expressed in Pacific Standard Time, when members may telephone the member services department for assistance and talk to a live person:

M-F____a.m. to _____p.m.; Sat. _____a.m. to _____p.m.; Sun. _____a.m. to ____p.m.

d. What is the physical location of the member services department?

e. How does the member access the member services department after hours for members services issues? (Check all that apply)

- ☐ Message system; member can leave message with health plan call back next business day
- ☐ Recorded message by health plan (i.e., hours of operation and directions for emergency)
- ☐ Interactive Voice Response System (IVR)
- ☐ Other (specify):

f. Indicate how the health plan monitors member services representatives and who conducts the monitoring activity (i.e., supervisor, quality department) utilizing the format below. (Check all that apply)

In the last column, please indicate the percent of calls or how many calls/day monitored.

Monitoring Mechanism	**Frequency of Monitoring**		**Monitored by:**	**% or # of Calls Per Representative**
	Employees with < mos	Employees with > 6 mos		
On-line ☐ Yes ☐ No				
Tape Recording ☐ Yes ☐ No				
Documentation Review ☐ Yes ☐ No				
☐ Other (specify)				
☐ None				

g. Indicate the mechanism(s) utilized to systematically document all incoming and outgoing telephone calls through member services. (Check all that apply)

☐ All calls are documented by logging into the call system
☐ Actual call is documented/data entered
☐ All calls tape recorded
☐ Call classified according to type of call
☐ Call classified by employer group
☐ Representative handing call is identified
☐ Date of call and resolution date is identified
☐ Tracking of calls to relate same caller to previous calls
☐ Other (specify)

h. What percentage of calls resolved on the first call for CY 2000? ____%

i. During CY 2000, for Medicare+Choice member issues not resolved on the first call, what is the percentage resolved within:

___ 1 day ___3 working days ___ 5 working days ___ more than 5 days

j. Provide the plan's targets for telephone performance and actual telephone performance for calendar year 1998 and 1999 utilizing the format below.

Performance Measures	Health Plan Target	2000 (actual)	1999 (actual)
1.Actual speed to answer* a) % calls answered in < 20 seconds b) % calls answered in 21-30 seconds c) % calls answered within 31-19 seconds d) % calls answered in >40 seconds			
2. Average abandonment rate			
3. Average number of daily calls per representative.			

**Indicate the actual speed to answer to reach a member services representative, not a prompt or message system.*

k. As Attachment XXX, provide the performance measure information in the table above on a monthly basis for CY 2000 for each business line on which you are bidding.

2. Customer Satisfaction.

a. Do you offer a consumer education web site? □ Yes □ No

b. (1) Do you offer an on-line provider directory? □ Yes □ No
(2) Are members able to identify specific physicians within a geographic area? □ Yes □ No

c. (1) Can a CalSTRS member send an email to customer service with a questions or comment? □ Yes □ No
(2) What is the expectation for customer service staff to respond?

d. Attachment XX, provide a comprehensive description of the complaints, provider appeals, member grievance escalation process and the documentation requirements.

e. Provide the number by type of complaints/inquiries, not grievances, received through the member services department for calendar year 2000.

Complaint/inquiry Type	Total number per 1000 members 2000 enrolled as of 12/31/99	Number resolved per 1000 members 2000	Number pending per 1000 members 2000
Mental Health Services			
Prescription Drugs/ Formulary			
Benefit Coverage Disputes			
Other			
Physician Access			
Appropriateness of Care			
Quality of Care			
Eligibility			
Identification Card Issues			
Other (Describe)			
# Complaints reported to Division Of Insurance			

f. Detail the special services available to ensure customer service access for the hearing impaired and visually impaired.

g. As Attachment XX, provide a comprehensive description of the member grievance procedure including process for filing grievances and turnaround time frames for resolution and appeals.

h. Indicate the health plan's targe t and actual percentage of member identification cards issued from the date the health plan receives notification (enrollment information) to the date the card is issued.

i. List any member satisfaction surveys conducted in calendar year 1999 (i.e., general satisfaction, disenrollment, etc.) utilizing the format below.

Type of Survey	Sample Size	Mail/Telephonic	Frequency*

**Frequency of actual survey, not sampling*

j. As Attachment XX, provide a sample of each member survey indicated above and 1999 results.

E. Administration *(All Bidders, each section)*

1. Current Data Management Practices *(All Bidders, each section)*

a. Please indicate below the current capabilities of your information systems. Please check each box that applies, and write in which data standard(s) (ANSI, NCPDP, LOINC, HL-7, other) your system can support.

	Tape or Disk Transmission		Online (via Modem)*	
Accept Enrollment Data from CalSTRS				
Accept Claims/Encounter data from Providers				
Accept Pharmacy Data from PBMs				

**NOTE: "ONLINE " means by direct transmission or via a clearinghouse, VAN or the Internet.*

b. Please indicate (x) the identifiers used by your internal systems for members/patients:

- ☐ Subscriber SS#
- ☐ Each Member SS#
- ☐ Subscriber SS# + Identifier
- ☐ Health Plan Unique Identifier
- ☐ Other(s)

c. Please indicate (x) the identifiers used by your internal systems for provider organization (medical groups, IPA, individually contracted medical providers, hospital systems, and the individual participating hospital(s)).

- ☐ Federal Tax ID
- ☐ Health Plan Unique Identifier
- ☐ Other(s)

d. Please indicate the identifier used by your internal systems for individual providers contracted through an IPA, medical group or hospital system.

- ☐ UPIN
- ☐ Federal Tax ID
- ☐ Health Plan Unique Identifier
- ☐ DEA Number
- ☐ State License Number

2. Enrollment

Plans are expected to be capable of receiving data via EDI, using the national data standard.

Means of Enrollment Data Receipt from Purchasers	**Percentage of Current Buyer Groups Utilizing EDI Eligibility Transmission (Give Best Estimate)**	
	Open Enrollment	**On-going Eligibility During Plan Year**
Online, *ANSI 834		
Online, *Non-standard		
Tape/Disk, ANSI 834		
Tape/Disk, Non-standard		
Paper Roster		
Paper Enrollment Forms		

**May include VAN, Internet*

3. Pharmacy Data: CalSTRS intends to contract separately for pharmacy services, however your organization may choose to bid on the pharmacy contract and it is CalSTRS intention that all service providers will cooperation in sharing data and jointly participate in patient case management. Therefore, please complete the following table to assure that CalSTRS fully understands your pharmacy relations and capabilities.

Pharmacy Management Company	Is Rx Data Coordinated w/ Master Patient Medical Record	Electronic Data		Data Format	Physician-Medical Group Access to Data
		To PBM	From PBM		

4. Efforts to enhance automation and electronic information exchange.

a. Please provide a narrative of current Information Technology initiatives, including a summary of your organization's technology master plan? Do you currently comply with the following HIPAA format? If not, when do you expect to implement these standards

HIPAA Standard	Standard Implement: (Date)	Standard Scheduled to be Implemented: (Date)	Project Leader &/or IS Consulting Support
Enrollment			
Claims--/Encounters			
Eligibility			
Referrals			
National Employer ID			
National Provider ID			

5. Protecting the Confidentiality of Member and Other Information.

a. Please enclose copies of your policies on security and confidentially, as Attachment

- ☐ Internal Record Security
- ☐ Medical Information
- ☐ Electronic Transfer of Eligibility Data
- ☐ Other Policies

6. Claims and Data Processing Systems

a. Provide the following information about the claims and data systems you expect would be used to support CalSTRS Medicare program, as Attachment:

- ☐ Name of System.
- ☐ Developed internally or externally, and by whom.
- ☐ Data system operational date.
- ☐ Is this the current system?
- ☐ What is the frequency of payments to providers (checkwrite) and the production of explanation of benefits for member?
- ☐ Please provide complete explanations of the claims processor's level of discretion and the policies related to a claim examiner's making a coding change.
- ☐ Is the production of client specific, provider specific or date specific claim expense reports routine or ad-hoc?
- ☐ Does your system allow the paying of one claim line and denial of a second claim line under the same document control number?
- ☐ How long is claims history maintained online?
- ☐ Average working days to process a clean claim? How long is a claim pended for eligibility, missing provider data, authorization, other insurance (coordination)?
- ☐ Please list the Medicare Intermediaries with whom your organization links electronically. Please list the various Medicare Intermediaries and the approximate percentage of claims your organization processes from each. Please give a complete description, including sample documents, of your organization's standard Medicare notifications sent to beneficiaries.
- ☐ Will CalSTRS have the ability to access claims history online from our site? Will there be real-time access?
- ☐ Provide all policies and procedures for fraud prevention and detection, with particular focus on Medicare fraud. How does your organization communicate to the Medicare Intermediary with possible abuse is detected?
- ☐ If you proposing a plan that will coordinate with Medicare, please describe your claims processing procedures and processing policies in detail.

b. Describe how your claims system interfaces with your medical management system, utilization review, quality measure identification, case management and provider profiling **.** Attachment XX.

F. Reporting

1. The standards for timely report: Weekly Reports – 5 Working Days; Monthly Reports - 30 calendar days after the last day of the month; Quarterly Reports - 45 calendar days after the last day of a quarter; and, Annual Reports - 60 calendar days after the last day of the plan year.

☐ Please confirm that your plan can produce the following required reports in the timeframe indicated.

☐ Any report for which your plan cannot meet the timeline, please indicate a timeline that you could accommodate. Use Attachment

☐ In Attachment XX, please list other reports that you regularly supply to large group purchaser/policy holders.

Reference to Performance Standards Section	Report Name	Frequency		Penalty
	Eligibility Tape Loading	Weekly	**All Plan Types**	Yes
	ID Cards SENT	Weekly	**All Plan Types**	Yes
	Telephone Response Time	Monthly	**All Plan Types**	Yes
	Telephone Abandonment Rate	Monthly	**All Plan Types**	Yes
	Response to written complaints	Quarterly	**All Plan Types**	Yes
	Disease Management Participation	Quarterly	**All Plan Types**	No
	Claims Turnaround	Quarterly	**HMO Supplement Medicare Select Medicare Supplement**	Yes
	Financial Accuracy of Claims Payment	Quarterly	**HMO Supplement Medicare Select Medicare Supplement**	Yes
	Claims Transactions	Quarterly	**HMO Supplement Medicare Select Medicare Supplement**	Yes
	Encounter Data	Semi-Annually	**Capitated HMO**	Yes
	Utilization Reports	Semi-Annually	**All Plan Types**	Yes
	Claims Lag Report	Quarterly	**HMO Supplement Medicare Select Medicare Supplement**	Yes
	Case Management Report	Quarterly	**All Plan Types**	Yes
	Catastrophic Case Report	Quarterly	**All Plan Types**	Yes
	Provider Network-Electronic Update	Monthly	**Capitated HMO HMO Supplement Medicare Select**	Yes

G. Questions for Medicare Supplement, Medicare Select and HMO Supplement bidders only.

1. Provide comprehensive policies and procedures for coordination of benefits with individual Medicare supplement plans, Medi-Cal, HMO supplements or other third party payors.

2. Describe in detail the procedures employed to ensure automatic benefit crossover with Medicare.

3. How does your plan handle Medicare crossover with claims processed by a Medicare intermediary for a state other than California?

4. Medicare Supplement Bidders Only

a. How does you plan intend to ensure excellence in customer satisfaction for participants that reside in other states?

b. As Attachment XXX, provide a copy of you Explanation of Benefits (EOB-member) and Explanation of Payment (EOP-provider) form for each of the three MediGap policy options proposed in the RFP. Please clearly identify how the various payment provisions will be identified for the member and the provider.

5. HMO Supplement Bidders Only

a. How does your plan handle Medicare eligible services that are not delivered in-network? Will you submit the claim to the Medicare Intermediary?

b. As Attachment XXX, provide a copy of your Explanation of Benefits (EOB-member) and Explanation of Payment (EOP-provider) form for services not delivered in network. Please clearly identify how the various payment provisions will be identified for the member and the provider.

6. Medicare Select Bidders Only

a. How does your plan handle Medicare eligible services not provide through the Select network? Will you submit the claim to the Medicare intermediary? What are procedures for interaction with a Medicare intermediary outside of California?

b. As Attachment XXX, provide a copy of you Explanation of Benefits (EOB-member) and Explanation of Payment (EOP-provider) form for each of the benefit design proposed in the RFP to which you are responding. Please clearly identify how the various payment provisions will be identified for the member and the provider.

c. Please provide a detailed explanation of the incentives for a Medicare beneficiary to utilize the Select network. How is the plan provision marketed to potential enrollees? (See Plan Design Table, page .)

H. Plan Marketing to CalSTRS Eligible Members

CalSTRS expects all participating plans to commit to the development and implementation of a comprehensive education and marketing effort to all members who are eligible to participate in this program. P lease provide responses to all of the following:

1. A narrative of similar marketing efforts your organization has implemented for other contracts, including preferred communication methods and materials distribution procedures.
2. A detailed discussion (with examples if available) of the marketing materials you would expect to be part of the campaign.
3. An estimated expected marketing budget specifically for reaching CalSTRS members for plan years one, two and three.
4. CalSTRS will require prior approval of all communications with eligible members. Plans will be prohibited from making marketing contact/outreach that have not been authorized. Failure to comply with this condition would trigger the penalty provisions.

II. **Cost Exhibits:** Please provide an **illustrative** premium quotation for a January 1, 2001 effective date. This date will not be the effective date of CalSTRS Medicare Supplement. It is expected that the effective date of the program will be January 1, 2002. CalSTRS expects to enter into actual premium negotiations with the finalists in the first quarter of 2001. The illustrative premiums will be a comparative tool for evaluating the various bids, but will only be viewed as a model of possible future pricing by a bidder.

Medicare Supplement						
	LA Basin	Southern CA, other	SF Bay Area	Central Valley, Urban	Other Northern CA	Outside of California
MediGap-type C						
MediGap-type F						
MediGap-type F						

Medicare Select						
	LA Basin	Southern CA, other	SF Bay Area	Central Valley, Urban	Other Northern CA	Outside of California
MediGap-type C						
MediGap-type F						
MediGap-type F						

HMO Plans						
	LA Basin	Southern CA, other	SF Bay Area	Central Valley, Urban	Other Northern CA	Outside of California
Medicare+Choice						
$0 Copay						
$5 Copay						
$10 Copay						
HMO Supplement						
$0 Copay						
$5 Copay						
$10 Copay						